TREATMENT OF PRURITUS OF THE ANUS AND GENITALIA

By HARRY E. ALDERSON *

DISCUSSION *by Kendal P. Frost, Los Angeles; Douglass W. Montgomery, San Francisco; Irwin C. Sutton, Hollywood; Charles E. Schoff, Sacramento; H. J. Templeton, Oakland; Frederick H. Rodenbaugh, San Francisco.*

PRURITUS of these regions may occur in either place and persist there or the itching may gradually involve both anus and genitalia. This is true of both sexes. Sooner or later lesions attributable to scratching or rubbing appear and complicate the situation, rendering therapy more difficult. This pruritus in the great majority of cases is largely of reflex origin, but local conditions enter into the process to a very considerable extent. For example, some pathological process in the rectum, prostate, deep urethra, seminal vesicles, bladder, uterus or other pelvic structure may be the cause; but local inflammatory or neoplastic changes in the anal or genital skin and mucosa or increased secretion of the same will aggravate the pruritus. Even a very small amount of secretion finding its way along anal fissures and creases will bring on paroxysms of severe itching. There are cases occasionally where the condition is entirely local in origin.

This distressing condition may be made very much worse by ill-considered treatment occasionally leading to serious complications. The stimulating action of tarry and other substances in common use for pruritus on a mucocutaneous area, already rendered eczematous by constant rubbing, may produce carcinoma. An aggravated example of this occurrence recently has come to my notice. Thus a purely inflammatory dermatological process may in time become a surgical condition with serious possibilities.

The agonizing itching that characterizes this trouble calls so urgently for relief that the victim must have something at once to alleviate his suffering. Sometimes if this can be accomplished over a period of a few days the vicious circle is broken and the violent scratching is stopped long enough for repair of damaged tissues to be accomplished. Then rational therapy based on etiology can be instituted. Local treatment is beneficial, but unless underlying etiological factors are eliminated permanent relief is not obtained. We often have cases due to disease of the deep urethra, prostate seminal vesicles, or related structures. Recently one came to our notice where paroxysms of severe perineal itching accompanied and followed the sexual orgasm, and persisted for some time. It is a very common experience to find internal hemorrhoids, fissures or other rectal pathology to be the main cause of the trouble. Likewise disease of the female pelvic organs with or without marked leukorrhea is often seen. If patients presenting any of these conditions have diabetes mellitus, naturally pruritus is more prone to develop and persist. There are cases too where the diet or gastrointestinal pathology (functional or organic) or intestinal parasites are the major factors. Excessive use of tobacco seems occasionally to be related to the trouble. Individuals with seborrheal skins also are more susceptible, and the local condition is more apt to become aggravated. In diabetics as well as in seborrheal patients, secondary infections become established more readily and local infection often has a great deal (but not everything) to do with the pruritus. We occasionally find a local streptococcus infection. Some have reported good results from the administration of streptococcus vaccine in these cases. They even recommend the treatment where no evidence of local infection is found. The finding of streptococci in the stools has been considered by some as sufficient reason for administering this vaccine therapy. It is difficult to understand how this treatment can be permanently successful where underlying pathology in some pelvic viscus is the primary reflex cause of the trouble. Naturally, the eliminating of a streptococcus or any other local infection should be one of the objects of treatment. Occasionally I have found an epidermophyton infection present, but never have I considered it to be the main cause. No doubt the good effects of the stronger mercurial, phenol or resorcin preparations used locally in such cases are due in part to their parasiticidal action. With causes acting reflexly, and underlying conditions having their unfavorable influences, it is evident that local treatment alone can never suffice. It goes without saying then that every effort should be made to find and eradicate these main factors. However, there are some local measures that will ameliorate the condition in most cases.

As spells of itching are often started by the presence of rectal, vaginal or skin secretion in the folds of the anal mucosa and skin, a rapidly drying nonirritating solvent is of use here. If this solvent contains an anipruritic agent it will give relief lasting for several hours. Carbontetrachloride C. P. containing ½ per cent of phenol or 2 per cent camphor has been very useful for these purposes. It penetrates the ducts, follicles, crypts, and folds in the skin, dissolves secretions and excretions destroying bacteria and fungi. It dries quickly. It has one objection, namely, the vapor from it may cause vertigo. This can be guarded against, however, by applying the solution carefully and providing for plenty of ventilation in the room. Sometimes it produces considerable smarting, but this lasts only a few minutes. To some patients this smarting gives welcome relief. Usually this "dry cleaning process" will relieve one from pruritus for the whole night. Some skins may require more oil. Then lanolin may be dissolved in the carbontetrachloride. After this application, a powder like magnesium carbonate or talcum may be dusted on. Sometimes calomel powder locally will be useful. Occasionally an ointment containing 10 per cent of calomel will help. In any event the carbontetrachloride should be applied at

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least twice daily as a cleanser. The using of a wet cloth instead of toilet paper is helpful sometimes. Hot compresses give great relief. I believe that this is due in part at least to the resultant emptying and cleansing of the skin and mucous membrane, ducts, crypts, and follicles. There are many antipruritic ointments, the best ones containing phenol. Ultraviolet light applied systematically will toughen the skin and inhibit bacterial growth, in this manner helping the local condition. In my experience, however, no local measures give symptomatic relief in as large a number of cases as do applications of carbontetrachloride solutions. Surgical removal of the area involved, nerve section, nerve injection and other measures to produce complete local anesthesia are mentioned here, only to be condemned. The results are apt to be only temporary, as nerve regeneration takes place rapidly. To do full justice to our patients we should exert every effort to discover and eradicate the underlying causes and not be satisfied with local therapy alone.

DISCUSSION

KENDAL P. FROST, M. D. (831 Pacific Mutual Building, Los Angeles)—Doctor Alderson's paper brings up a condition which is always with us, and his suggestion of carbontetrachloride is a welcome addition to our therapeutic agents. I can do no more than to add my plea to Alderson's that the internal pathological condition which underlies practically every case of pruritus ani must be taken care of, else the pruritus is bound to recur no matter what local treatment is used. I do not consider pruritus ani a disease *per se*, but a sympathetic expression of pathological disturbances in the lower intestinal tract and other pelvic organs except where there happens to be a localized manifestation of some definite skin disease, in which case internal factors may have a determining effect on localization of the skin manifestation. We see eczema, particularly of the seborrheic type, psoriasis, epidermophyton infections, as well as many other skin conditions connected with this disorder. They all resist local measures unless the underlying, the pathological, disturbance is taken care of. Alderson's suggestion of carbontetrachloride as a cleansing agent is noteworthy. Most patients with pruritus ani are careless of their personal hygiene in this area, and proper cleansing is an important factor in their care.

D. W. MONTGOMERY, M. D. (323 Geary Street, San Francisco)—It is interesting to note the increasing attention dermatologists give to the troublesome symptom called pruritus ani. A few years ago one would not hear this affection mentioned in a meeting of this kind; now it is repeatedly touched upon both formally and casually. As Alderson says, pruritus ani may arise from many causes, but possibly the greatest proximate cause is congestion. Congestion in its turn may arise from many causes, of which that sluggish habit of the body called constipation is the most frequent. And one of the most frequent causes of this sluggish condition is the sedentary habit. The sedentary habit is a characteristic of the age in which we live. A few years ago the only industrial people who sat at their work were tailors and shoemakers; now there are thousands whose occupation entails sitting for many hours of each day as, for instance, stenographers, telephone operators, and those who ride much in an automobile. These seem to me to be the main reasons for the great increase in the number of people suffering from pruritus ani.

IRWIN C. SUTTON, M. D. (Taft Building), Hollywood, California)—Doctor Alderson's paper is timely, inasmuch as there is an increasing number of people with "desk jobs." To those who must sit on a hard seat, I insist that they provide themselves with a feather pillow, which helps to carry off the perspiration and prevents friction of the anal region. Tight and rasping underclothes must not be worn. Wiping and patting the anus with a pledget of cotton dipped in a saturated solution of boric acid is a valuable substitute for the use of the bleached toilet papers now on the market. The remarks on the overuse of tars are pertinent, although I have had good results from liquor carbonis detergens diluted with an equal part of olive oil and used liberally on the anal region.

CHARLES E. SCHOFF, M. D. (Farmers and Mechanics' Bank Building, Sacramento) — Doctor Alderson has brought to our attention a very valuable therapeutic agent for the relief of the pruritis accompanying certain pathological conditions affecting the region of the anal orifice and genitalia.

Particular attention should be drawn to the fact that it is not offered as a curative measure, but as a means of relief to those suffering from this annoying affliction.

I have had the opportunity of using it in a limited number of patients, and it has been most gratifying, particularly when used in combination with either phenol or camphor. The ease and cleanliness of the application, its chemical, mechanical and therapeutic virtues commend carbontetrachloride C. P. to the physician for trial.

Underlying pathological lesions, of course, should be sought and eradicated if possible; dependence upon the drug as a specific agent to remove all causes will meet with disappointment.

H. J. TEMPLETON, M. D. (3115 Webster Street, Oakland, California)—Doctor Alderson's paper is a most excellent summary of modern knowledge of pruritus ani. Just as in any other symptom, the cause must be sought out and removed. This is of the greatest importance. However, in our enthusiasm in this quest we must not overlook that for which the patient consulted us, namely, relief. I have seen some very good results from the use of carbontetrachloride as recommended by Alderson. The remedy which has worked the best in my hands is the x-ray. This is practically always palliative and sometimes curative. I give one-half skin unit of unfiltered rays every two weeks, giving up to four or five such treatments if necessary. In the meanwhile the cause is determined and remedied if possible.

FREDERICK H. RODENBAUGH, M. D. (490 Post Street, San Francisco)—I am not qualified to discuss the dermatological aspect of Doctor Alderson's paper, but as a roentgenologist frequently treat this condition. The results, in my experience, have been most satisfactory.

I have found that the majority of patients are relieved by a dosage of from one-quarter to one-half filtered unit given at weekly intervals. It has not been my practice to continue treatment if there has been no response from the first three treatments. It is my impression that if a patient will react favorably to x-ray there will be some relief following a single treatment, and if this does not occur it will probably not respond to the x-ray. These patients should have local treatment if needed as no permanent relief can be expected until the local irritation is cured.

The dosage to secure results is safe and can be used repeatedly with no harmful effect.

DOCTOR ALDERSON (closing)—I wish to thank the discussants very much for their remarks. As most of these patients are seen by dermatologists, it is worth while bringing the subject up for discussion occasionally.

"Pabst Extract—The 'Best' Tonic" not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Pabst Extract—The "Best" Tonic is claimed to be "pure extraction of malt, properly flavored and combined with hops and is preserved by no other means than pasteurization." The preparation is stated to contain alcohol, by volume, 3.70 per cent, and 1.45 gm. of hops are used for the preparation of 12 fluid ounces of "tonic." The Council found Pabst Extract—The "Best" Tonic unacceptable for New and Nonofficial Remedies because (1) the name does not indicate the potent constituents—malt and hops—of the mixture; (2) the claim "The 'Best' Tonic" is not warranted; (3) the therapeutic claims are unwarranted; and (4) it is sold to the public with claims that tend to its indiscriminate and ill-advised use.—Journal A. M. A.

You can't start a revolution in a land where everybody knows what a niblick is.